Department of Community Health
State Health Benefit Plan

Dependent Student Status Information

(For Dependent Students Age 19 through 25 only)

Return Form to:
Eligibility Section
Health Benefit Services
P. O. Box 1990
Atlanta, GA 30301-1990

I. Employee/Member Information

Social Security Number

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence | Daytime Telephone Number

IMPORTANT: Both Sections I and II must be completed and Section III must be signed and dated before student coverage can be extended.

II. Dependent Student Information

Student's Social Security Number

Last Name | First | Initial

Sex	Date of Birth			Marital Status
	Month	Day	Year	
☐ Male				☐ Single
☐ Female				☐ Married
				☐ Divorced

Expected Graduation Date

What is the anticipated (or actual) date of graduation for the current program or plan of instruction?	Month	Day	Year

Is it the student's intention that he/she will attend an accredited school full-time next quarter/semester? Yes ☐ No ☐

Is the dependent employed full-time? Yes ☐ No ☐
If yes, is health benefit coverage provided through the employer? Yes ☐ No ☐

Conditions and Instructions (Read Before Completing This Form)

Requirements for student coverage. The dependent student must be:

(1) age nineteen (19) through twenty-five (25);

(2) in regular full-time attendance at an accredited school (the number of hours required for full-time status is defined by the individual school);

(3) not employed in a benefits eligible position; and,

(4) never married and otherwise eligible for dependent coverage.

Required Documentation. Dependent student status must be documented by a **Certification Letter** which includes:

(1) the date(s) of enrollment for both current and previous quarters/semesters;
(2) the number of credit hours taken each period;
(3) the enrollment status for each period; and,
(4) the expected date of graduation.

Note: Letters of acceptance, student ID cards, class schedules, and billing/payment invoices/receipts are not valid certification to prove final registration letters. Proof of Pre-registration/acceptance letter can be submitted to extend coverage for (1) month until final Certification Letter is received.

Termination of student coverage. Coverage for a dependent student ends/terminates:

(1) at the end of the month in which the student completes academic requirements for graduation; or,

(2) upon ceasing attendance unless the student has attended the previous three consecutive quarters (or two semesters) and intends to return following an absence of one quarter (or one semester); or,

(3) if students status information is not received by coverage expiration date.

Instructions. Please review and complete the information requested above. Read the Certification Statement below, then sign and date this form. Staple the **Certification Letter** from the Registrar's office to the form and return the form to the address shown above. Prompt updates will prevent a delay in claim processing or verification of coverage. If the dependent does not remain a full-time student, the member must notify the SHBP Eligibility Section (at 404-656-6322 or 1-800-610-1863) immediately.

III. Certification/Attestation by Employee/Member

I do hereby attest that the above information is true and correct to the best of my knowledge. I further acknowledge and understand that I may be subject to a fine of not more then $1000 or imprisonment for not less than one and no more than five years, or both, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding the information reported on this form or other information pursuant to O.C.G.A. Section 16-10-20.

x _____ _____

Signature of Employee/Member | Date: